DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445298	A. BUILDING _____ B. WING _____	08/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ATHENS	1234 FRYE STREET, PO BOX 788 ATHENS, TN. 37371

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide dignity for one (#40) of thirty-five residents reviewed. The findings included:	F 164	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #40 curtain was pulled the rest of the way by CNA #4 on 8/5/13 immediately following observation. CNA #4 was educated by Unit Manager on 8/5/13 to ensure that residents who are exposed while lying in bed and in view to the hallway are concealed by a privacy curtain and that resident dignity is being met. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that reside in the facility have the potential to be affected. Licensed and non-licensed staff will be educated by the Staff Development Coordinator by 8/26/13 to ensure that residents who are exposed while lying in bed and in view to the hallway are concealed by a privacy curtain and that resident dignity is being met. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;** Licensed and non-licensed staff will be educated by the Staff Development Coordinator upon hire and annually to ensure that residents who are exposed while lying in bed and in view to the hallway are concealed by a privacy curtain and that resident dignity is being met. Observation audits will be conducted by Unit Managers	09/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 9/27/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 Resident #40 was re-admitted to the facility on January 25, 2013, with diagnoses including Diabetes Mellitus, Dementia, Hypertension, Abnormal Gait, and Abdominal Aorta Aneurysm. Observation on August 5, 2013, at 3:20 p.m., in the resident's room revealed the resident was lying on the bed with a brief in place with the privacy curtain drawn part of the way. Continued observation revealed the privacy curtain was not pulled far enough to conceal the resident wearing the brief and exposed to view from the hallway. Interview with Certified Nurse Assistant #4 on August 5, 2013, at 1:20 p.m., confirmed the dignity of the resident was not provided when the curtain was not pulled far enough to conceal the resident wearing the brief and exposed to view from the hallway.	F 164	weekly X4 and Monthly X2 to ensure that resident dignity is being met. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Director of Nursing to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to assess for the use of restraints for two residents (#113, #152) of thirty-five residents reviewed. The findings included:	F 221	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #113 and #152 initial restraint assessments were completed by the Director of Nursing on 8/5/13. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that reside in the facility that utilize a contour mattress and foam rolls have the potential to be affected. 100% of residents utilizing a contour mattress and foam rolls were assessed for the use of restraints by the Assistant Director of	09/26/13

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F 221	Continued From page 2 Resident #113 was admitted to the facility on May 31, 2013, with diagnoses including Dementia, Healing Left Hip Fracture, Anemia, and Behavioral Disturbances. Medical record review of the quarterly Minimum Data Set (MDS) dated July 27, 2013, revealed the resident had severe cognitive impairment, required extensive assistance of two for transfer, and no restraints in use. Medical record review of the Care Plan dated May 31, 2013, revealed no problem, goal, and/or approach for a restraint. Medical record review of a Post Fall Screening Tool dated June 9, 2013, revealed "...resident found sitting next to bed...suggestions: contour mattress..." Medical record review of a Nursing Home Note dated June 14, 2013, revealed "...attempting to jump out of bed...we are going to put some barrier at the side of the bed..." Medical record review of a Post Fall Screening Tool dated June 16, 2013, revealed "...resident was found on perimeter mat at bedside...suggestions: foam rolls to bed..." Medical record review of a Weekly Summary dated June 21, 2013, revealed restraints not used. Medical record review of a Plan of Treatment dated July 29, 2013, revealed "the patient is able to safely transition from supine to sitting position...patient is able to safely transfer from bed to wheelchair..."	F 221	Nursing on 8/6/13. Director of Nursing and Staff Development Coordinator educated licensed nursing staff on 8/7/13 to ensure that residents are assessed for the use of restraints prior to the placement of a contour mattress and/or foam rolls. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;** Licensed nursing staff will be educated by the Staff Development Coordinator upon hire and annually to ensure that residents are assessed for the use of restraints prior to the placement of a contour mattress and/or foam rolls. Assistant Director of Nursing will complete a 100% audit of residents who receive new orders for a contour mattress and/or foam rolls weekly X4 and monthly X2 to ensure that the initial restraint assessment is completed prior to implementation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Director of Nursing to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated.	

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F 221	Continued From page 3 Medical record review of the Physician's Recapitulation Orders dated August 2013 revealed "...Contour Mattress to Bed...Foam Rolls to Bilat (bilateral) Sides of Bed to Define Bed Parameter..." Medical record review of Initial and Quarterly Restraint Assessment dated August 5, 2013, revealed restraint crossed out and replaced with the word positioning. Continued medical review of the assessment revealed "...res (resident) has foam roll...res has poor safety awareness..." Medical record review revealed no restraint assessment for the use of the contour mattress and foam rolls. Review of facility policy, Physical Restraint Use, dated March 2007 revealed "...Policy...physician's order is required to apply any type of restraint...Documentation in nurses' notes includes type of restraint, date, time of use, reason for use, and resident tolerance...Restraints are used to:...Prevent unsupervised ambulation of residents with documented impaired and unsafe ambulation skills...The interdisciplinary approved plan for restraint use is outlined in the resident care plan..." Observation on August 5, 2013, at 11:35 a.m., in the resident's room, revealed the resident sitting on the side of the bed, legs over the foam roll and contour mattress, feet not touching the floor, yelling "I need help." Continued observation revealed the left side of the bed against the wall, contour mattress in place and a foam roll placed parallel to the right side of the bed against the	F 221		

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F 221	Continued From page 4 contour mattress. Observation on August 5, 2013, at 4:14 p.m., in the resident's room revealed the resident sitting on the side of the bed, legs over the foam roll and contour mattress, feet not touching the floor, yelling "I can't get up." Continued observation revealed the left side of the bed against the wall, contour mattress in place and a foam roll placed parallel to the right side of the bed against the contour mattress. Observation on August 5, 2013, at 4:15 p.m., with the Assistant Director of Nursing (ADON), in resident #113's room revealed the resident sitting on the side of the bed attempting to exit the bed, yelling "I can't get up." Interview on August 5, 2013, at 4:15 p.m., in resident #113's room, with the ADON confirmed the resident could not remove the foam roll and the resident could exit the bed if the foam roll had not been in place. Interview on August 6, 2013, at 2:16 p.m., with the Director of Nursing (DON), in the DON's office, confirmed no assessment had been completed for the use of the contour mattress and the foam rolls as a restraint. Resident #152 was admitted to the facility on December 13, 2012, with diagnoses of Chronic Airway Obstruction, Coal Workers Pneumoconiosis, Hypertension, and Dementia with Behavioral Disturbances. Review of the Comprehensive Minimum Data Set (MDS) dated June 24, 2013, revealed the resident was severely cognitively impaired,	F 221		

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F 221	Continued From page 5 required extensive assistance with activities of daily living, had upper and lower extremity limitations in range of motion and used physical restraints while in a chair or out of bed. Continued review revealed no documentation of bed restraints in use. Observation of the resident on August 6-7, 2013, revealed the residents bed with a foam roll lying parallel to the contour mattress, beneath the bed sheets, on the exit side of the bed. Continued observation revealed the opposite side of the bed was against the wall. Review of the Initial and Quarterly Restraint Assessment dated June 19, 2013, revealed no documentation of the use of bed restraints. Interview with the DON, on August 7, 2013, at 9:30 a.m., in the DON's office confirmed the facility had failed to assess the foam roll and contour mattress with bed bolsters as restraints.	F 221		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, review of facility investigations, and review of facility policies, the facility failed to follow policy and procedure for investigating an allegation of	F 226	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Statement was received from CNA #1 by Director of Nursing on 8/6/13. Regional Vice President and Regional Director of Clinical Services educated Executive Director and Director of Nursing on facility's policy and procedure for investigating an allegation of abuse on 8/7/13.	09/26/13

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F 226	Continued From page 6 abuse for one of five abuse investigations reviewed. The findings included: Resident #77 was admitted to the facility on May 3, 2013, with diagnoses including Diabetes Mellitus, Cellulitis, Congestive Heart Failure, Decubitus Ulcer, and Hypertension. Interview with the resident on August 6, 2013, at 12:27 p.m., in the resident's room revealed the resident had reported to the facility approximately one month ago a Certified Nursing Assistant (CNA) had tried to kiss the resident. Review of a facility investigation revealed witness statements from the resident and two of three CNA's present at the time of the incident. Interview with CNA #3 on August 6, 2013, at 3:32 p.m., in the conference room via telephone revealed CNA #3 had written a statement about the incident on May 27, 2013. CNA #3 confirmed being present in the room at the time of the incident and the alleged perpetrator had not tried to kiss the resident. Interview with CNA #1 on August 6, 2013, at 4:05 p.m., in the conference room via telephone, revealed CNA #1 had not written a statement stating "...I was not asked to give a statement..." CNA #1 confirmed being present in the room at the time of the incident and the alleged perpetrator had not tried to kiss the resident. Interview with Registered Nurse (RN #1), on August 6, 2013, at 4:18 p.m., at the 100 nursing station revealed the RN investigated the alleged	F 226	**How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that reside in the facility have the potential to be affected. All other abuse investigations that were conducted by the facility after the Health and Life Safety Code recertification survey conducted on 10/31/11 were reviewed by the Regional Director of Clinical Services, Executive Director and Director of Nursing on 8/7/13 with no other concerns identified. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;** All abuse investigations will be reviewed by the Executive Director, Director of Nursing, Regional Vice President and Regional Director of Clinical Services to ensure that the facility followed policy and procedure for investigating an allegation of abuse. The Regional Vice President and/or Regional Director of Clinical Services will audit 100% of facility abuse investigations weekly X4 and monthly X2 to ensure that the facility followed policy and procedure for investigating an allegation of abuse. Audit results will be reported to the Executive Director by the Regional Vice President and/or Regional Director of Clinical Services to report to the Performance Improvement Committee.	

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F 226	Continued From page 7 abuse the day after the event occurred which was when the resident reported the incident. Further interview confirmed a witness statement was obtained from CNA #3, but had not been obtained from CNA #1 because CNA #1 was not working on May 27, 2013. Review of facility policy and procedure, Abuse and /or Neglect Investigation, revised February 2009 revealed "...investigation shall include a written summary of...interviews with any witnesses to the incident..." Interview with the Director of Nursing (DON), on August 7, 2013, at 9:00 a.m., in the DON office, revealed the facility's policy was to "...typically perform interviews..." when investigating abuse allegations. The DON confirmed the facility had failed to obtain a witness statement from CNA #1 and the facility's policy for investigating allegations of abuse had not been followed.	F 226	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Executive Director to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #43 care plan was updated to reflect instructions for knee braces, pressure relief cushions, and/or positioning in the wheelchair by the Care Plan Coordinator on 8/6/13. Resident #120 care plan was updated to reflect blood pressure/blood draw precautions in the extremity with the shunt by the Care Plan Coordinator on 8/6/13. Care Plan Coordinators were educated by the Director of Nursing on 8/6/13 to ensure care plans/care directives include instructions for knee braces, pressure relief	09/26/13

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F 279	Continued From page 8 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a comprehensive care plan for two residents (#43, #120) of thirty-five residents reviewed. The findings included: Resident #43 was admitted to the facility on September 9, 2013, with diagnoses including Depression, Dementia, Congestive Heart Failure, and Abnormality of Gait. Medical record review of the quarterly Minimum Data Set (MDS) dated July 11, 2013, revealed the resident was severely impaired cognitively and required limited assistance of one for locomotion off the unit with guided maneuvering of limbs. Medical record review of the Care Plan last updated July 24, 2013, revealed no care plan for a knee brace, pressure relief cushion, and/or positioning. Medical record review of a Nursing Rehabilitation/Restorative Care form dated March 12, 2013, revealed "...apply brace to R (right) knee..." Medical record review of a Rehabilitation Services	F 279	cushions, and/or positioning in the wheelchair and that blood pressures/blood draw precautions are care planned. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that reside in the facility have the potential to be affected. 100% audit of resident care plans and care directives was started by the Care Plan Coordinators on 8/6/13 and will be completed by 9/26/13 to ensure that care plans/care directives include instructions for knee braces, pressure relief cushions, and/or positioning in the wheelchair and that blood pressures/blood draw precautions are care planned. Licensed nursing staff will be educated by the Director of Nursing and/or Staff Development Coordinator by 8/26/13 to ensure care plans/care directives include instructions for knee braces, pressure relief cushions, and/or positioning in the wheelchair and that blood pressures/blood draw precautions are care planned. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;** Licensed nursing staff will be educated by the Staff Development Coordinator upon hire and annually to ensure care plans/care directives include instructions for knee braces, pressure relief cushions, and/or positioning in the wheelchair and that blood pressures/blood draw precautions are care	

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F 279	Continued From page 9 Multidisciplinary Screening Tool dated July 17, 2013, revealed "...No functional changes...would benefit from a pressure relief cushion which was issued today..." Medical record review of a Care Directive (Certified Nurse Aide care plan) dated August 5, 2013, revealed no instructions for knee brace, pressure relief cushion, and/or positioning in the wheelchair. Observation on August 5, 2013, at 11:37 a.m., on the West Wing Hall revealed a staff member pushing the resident in the wheelchair with a pressure relief cushion. Continued observation revealed the resident's legs without support unable to reach the floor and a brace on the right knee. Observation on August 6, 2013, at 1:00 p.m., on the West Wing revealed the resident propelling self in the wheelchair. Continued observation revealed a pressure relief cushion in place, bilateral legs without support, and a knee brace on the right knee. Interview with the Director of Nursing (DON) on August 6, 2013, at 1:38 p.m., in the West Wing Nurses Station confirmed the Care Plan did not include any approaches or interventions for the knee brace to the right knee for contractures, pressure relief cushion to the wheelchair, and/or positioning. Resident #120 was admitted to the facility on July 5, 2011, with diagnoses including End Stage Renal Disease, Diabetes, and Nephritis. Medical record review of the resident current	F 279	planned. Assistant Director of Nursing will complete a 10% audit of resident care plans and care directives weekly X4 and monthly X2 to ensure care plans/care directives include instructions for knee braces, pressure relief cushions, and/or positioning in the wheelchair and that blood pressures/blood draw precautions are care planned. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Director of Nursing to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated.	

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LIFE CARE CENTER OF ATHENS	1234 FRYE STREET, PO BOX 786 ATHENS, TN 37371

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F 279	Continued From page 10 Care Plan last updated June 12, 2013, revealed "...shunt to left arm..." Continued review of the Care Plan revealed the Care Plan did not address blood pressure/ blood draw precaution in the left arm. Observation on August 7, 2013, at 9:34 a.m., revealed resident #120 resting in bed. Continued observation revealed the resident with a dialysis shunt to the left arm. Interview with the DON, in the DON's office, on August 6, 2013, at 1:24 p.m., confirmed the care plan did not address blood pressures/ blood draw precautions in the left extremity.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #40 care plan was updated to include approaches of addressing the resident's behavior of exposing self by the Care Plan Coordinator on 8/7/13. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with a behavior of exposure have the potential to be affected. 100% audit of resident care plans with a behavior of exposure was started by the Care Plan Coordinators on 8/7/13 and will be completed by 9/26/13 to ensure that care plans include approaches to address the resident's behavior of exposing self. Licensed nursing staff will be educated by	09/26/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan to address dignity for one (#40) of thirty-five resident's reviewed. The findings included: Resident #40 was re-admitted to the facility on January 25, 2013, with diagnoses including Diabetes Mellitus, Dementia, Hypertension, Abnormal Gait, and Abdominal Aorta Aneurysm. Medical record review of the resident's Care Plan dated January 25, 2013, revealed "...Pt. (patient) keep Brief Pulled Down and stays uncovered while in bed..." No approaches to address the resident's behavior of exposure were found. Observation on August 5, 2013, at 3:20 p.m., in the resident's room revealed the resident was lying on the bed wearing a brief and the privacy curtain was drawn part way. Continued observation revealed the privacy curtain was not pulled far enough to conceal the resident wearing a brief and exposed to view from the hallway. Interview with Minimum Data Set Coordinator (MDS #1) on August 7, 2013, at 8:45 a.m., in the MDS office confirmed no approaches to address the resident's behavior of exposing self had been implemented.	F 280	the Director of Nursing and/or Staff Development Coordinator by 8/26/13 to ensure that resident care plans with a behavior of exposure include approaches to address the resident's behavior of exposing self. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;** Licensed nursing staff will be educated by the Staff Development Coordinator upon hire and annually to ensure that resident care plans with a behavior of exposure include approaches to address the resident's behavior of exposing self. Assistant Director of Nursing will complete a 10% audit of resident care plans with a behavior exposure weekly X4 and monthly X2 to ensure that resident care plans with a behavior of exposure include approaches to address the resident's behavior of exposing self. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Director of Nursing to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		09/26/13

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F 309	Continued From page 12 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess for positioning of one resident (#43), and failed to obtain a physician's order for dialysis for one resident (#120) of thirty-five residents reviewed. The findings included: Resident #43 was admitted to the facility on September 9, 2013, with diagnoses including Depression, Dementia, Congestive Heart Failure, and Abnormality of Gait. Medical record review of the quarterly Minimum Data Set (MDS) dated July 11, 2013, revealed the resident was severely impaired cognitively and required limited assistance of one for locomotion off the unit with guided maneuvering of limbs. Medical record review of the Care Plan last updated July 24, 2013, revealed no care plan for a knee brace, pressure relief cushion, and/or positioning. Medical record review of a Nursing Rehabilitation/Restorative Care form dated March 12, 2013, revealed "...apply brace to R (right) knee..."	F 309	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #43 was assessed for positioning by occupational therapy on 8/6/13. Resident #120 Physician was notified by Director of Nursing and clarification orders were received for dialysis on 8/6/13. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that reside in the facility that utilize pressure relief cushions and/or receiving dialysis have the potential to be affected. Staff Development Coordinator will educate licensed staff by 9/6/13 to ensure that residents are evaluated for proper positioning after a pressure relief cushion has been placed. Director of Nursing educated Health Information Management Director on 8/6/13 to ensure that resident dialysis orders are printed on the monthly physician recapitulation orders. 100% audit of residents that utilize pressure relief cushions to evaluate for proper positioning were started on 8/6/13 by occupational therapy and will be completed by 9/26/13. All residents that receive dialysis were audited by the Director of Nursing on 8/6/13 to ensure that the Physician was notified and clarification orders were obtained if needed.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 13 Medical record review of a Rehabilitation Services Multidisciplinary Screening Tool dated July 17, 2013, revealed "...No functional changes...would benefit from a pressure relief cushion which was issued today..." Medical record review of a Care Directive (Certified Nurse Aide care plan) dated August 5, 2013, revealed no instructions for knee brace, pressure relief cushion, and/or positioning. Observation on August 5, 2013, at 11:37 a.m., on the West Wing Hall revealed a staff member pushing the resident in the wheelchair. Continued observation revealed the resident's legs without support and unable to reach the floor and a brace on the right knee. Observation on August 6, 2013, at 1:00 p.m., on the West Wing revealed the resident propelling self in the wheelchair. Continued observation revealed the bilateral legs with no support and a knee brace on the right knee. Interview with Physical Therapist #1 on August 6, 2013, at 1:10 p.m., in the restorative gym revealed the resident had no support for the lower extremities. Interview with the Director of Nursing (DON) on August 6, 2013, at 1:38 p.m., in the West Wing Nurse's Station revealed Occupational Therapy had assessed the resident on July 17, 2013, and a new pressure cushion had been placed in the resident's wheelchair. Continued interview revealed the cushion prevented the resident's feet from touching the floor. Further interview confirmed the facility had failed to evaluate the	F 309	**What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;** Licensed staff will be educated by the Staff Development Coordinator upon hire and annually to ensure that residents are evaluated for proper positioning after a pressure relief cushion has been placed. All residents admitted on dialysis will be reviewed by Assistant Director of Nursing to ensure that dialysis order has been obtain and written on the monthly physician recapitulation orders. Director of Rehab Services will complete a 10% audit of all residents that utilize pressure relief cushions weekly X4 and monthly X2 to ensure that they were evaluated for proper positioning. Director of Nursing will audit 100% of residents admitted on dialysis weekly X4 and monthly X2 to ensure that dialysis order has been obtain and written on the monthly physician recapitulation orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Director of Rehab Services and Director of Nursing to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated.	

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F 309	Continued From page 14 resident for positioning after the cushion had been applied to the wheelchair. Resident #120 was admitted to the facility on July 5, 2011, with diagnoses including End Stage Renal Disease, Diabetes, and Nephritis. Medical record review of the current Care Plan last updated June 12, 2013, revealed "...dialysis 3d (three days)..." Continued medical record review of the current Physician Recapitulation Orders signed July 9, 2013, revealed no documentation of an order for dialysis. Interview with the DON, in the DON's office, on August 6, 2013, at 1:24 p.m., confirmed the facility failed to obtain an order for dialysis.	F 309	F312 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #40 toenails were trimmed by the Treatment Nurse on 8/7/13. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	09/26/13
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide nail care for one (#40) resident of thirty-five residents reviewed. The findings included: Resident #40 was re-admitted to the facility on January 25, 2013, with diagnoses including Diabetes Mellitus, Dementia, Hypertension, Abnormal Gait, and Abdominal Aorta Aneurysm.	F 312	All residents who reside in the facility have the potential to be affected. 100% of resident toenails were assessed by the treatment nurses on 8/7/13 to ensure that resident toenail care is provided. Nursing staff will be educated by the Staff Development Director by 8/26/13 to ensure that resident toenail care is provided. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;** Licensed and non-licensed nursing staff will be educated by the Staff Development Coordinator upon hire and annually to ensure that resident toenail care is provided. Unit Managers and/or Treatment Nurses will audit 10% of all residents weekly X4 and monthly X2 to ensure that resident nail care is provided.	

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F 312	Continued From page 15 Observation on August 5, 2013, at 10:00 a.m., in resident #40's room revealed the resident was lying on the bed with no socks or shoes and the resident's toenails were long and jagged. Observation and interview on August 7, 2013, at 8:50 a.m., with Minimum Data Set Coordinator #1 and Certified Nurse Assistant #5 in the resident's room confirmed the resident's toenails were long and jagged and required trimming.	F 312	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Director of Nursing to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility dietary department failed to maintain dietary equipment in a sanitary manner. The findings included: Observation and interview with the Certified Dietary Manager on August 5, 2013, beginning at 9:08 a.m., confirmed the following: 1) The walk-in refrigerator had water dripping	F 371	F371 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The following observations made on 8/5/13 were corrected as followed: 1) Sprinkler head in walk-in refrigerator was wiped off and assessed by the Certified Dietary Manager and Director of Maintenance on 8/5/13. 2) Spoiled tomatoes were disposed of by the Certified Dietary Manager on 8/5/13. 3) Ice build-up on door latch in the walk-in freezer was removed by the Director of Maintenance on 8/5/13. 4) Ice cream freezer was defrosted to remove ice build-up from chest interior by Dietary Aide on 8/10/13. 5) The exterior of the ovens, fryer, and reach-in refrigerator/freezer doors were cleaned by the Assistant Dietary Manager and Dietary Aide on 8/5/13. 6) The reach-in refrigerator door gasket was cleaned by the Certified Dietary Manager on 8/5/13. 7) The	09/26/13

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F 371	Continued From page 16 from the sprinkler head. 2) The walk-in refrigerator had two spoiled tomatoes stored in a case of tomatoes. 3) The walk-in freezer door had a build-up of ice on the door latch. 4) The ice cream freezer chest interior had a build-up of ice. 5) The exteriors of the ovens, fryer, reach-in refrigerator/freeze doors had debris present. 6) The reach-in refrigerator door gasket had blackened debris present. 7) The reach-in freezer floor had debris present. Observation and interview with the Certified Dietary Manager on August 5, 2013, beginning at 4:05 p.m., confirmed the following: 1) The two door reach-in refrigerator storage racks had blackened debris present. 2) The interior and exterior corners of approximately a dozen sheet pans, stored on the clean storage rack, had heavy accumulation of blackened debris. 3) The walk-in refrigerator had a vacuum packed pre-cook ham stored in direct contact with the raw cabbage. 4) The silver ware storage cart had an accumulation of sticky dusty debris. 5) The ice machine interior ice dispenser slot had a build-up of scale. 6) The grill corners and spill pan slot had an accumulation of blackened debris. Observation and interview with the Assistant	F 371	reach-in freezer door was cleaned by the Certified Dietary Manager on 8/5/13. The following observations made on 8/6/13 were corrected as followed: 1) The shelving storage unit on the right side as you enter the walk-in refrigerator was disposed of by the Director of Maintenance on 8/6/13. 2) The supporting legs and shelves of the shelving unit containing clean dishes in the dish room were cleaned by the Assistant Dietary Manager and Dietary Aide on 8/6/13. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that reside in the facility have the potential to be affected. A dietary observation audit that included 100% of the following: 1) sprinkler heads in the walk-in refrigerator, 2) produce storage, 3) freezers, 4) dietary equipment, 5) walk-in refrigerator/freezer doors and door gaskets, and 6) shelving storage units was completed by the Certified Dietary Manager on 8/6/13 to ensure that food storage and equipment is maintained in a sanitary manner. Dietary staff will be educated to utilize routine cleaning and daily expiration check schedules by the Certified Dietary Manger by 8/26/13 to ensure that food storage and equipment is maintained in a sanitary manner. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;**	

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F 371	Continued From page 17 Dietary Manager on August 6, 2013, beginning at 7:37 a.m., confirmed the following: 1) The shelving storage unit on the right side as you enter the walk-in refrigerator, had three rusted shelves with various cases of food stored on the shelves. 2) The shelving unit containing clean dishes in the dish room had an accumulation of sticky blackened debris on the supporting legs and shelves.	F 371	Dietary staff will be educated by the Certified Dietary Manager upon hire and annually to utilize routine cleaning and daily expiration check schedules to ensure that food storage and equipment is maintained in a sanitary manner. Dietary observation audits will be completed by the Assistant Dietary Manager and/or Certified Dietary Manager to include: 1) sprinkler heads in the walk-in refrigerator, 2) produce storage, 3) freezers, 4) dietary equipment, 5) walk-in refrigerator/freezer doors and door gaskets, and 6) shelving storage units weekly X4 and monthly X2 to ensure that food storage and equipment is maintained in a sanitary manner.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Certified Dietary Manager to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. F431 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	09/26/13

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F 431	Continued From page 18 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to appropriately store medications and chemicals and to monitor the temperature refrigerator storage area for one of two medication storage rooms observed. The findings included: Observation of the 100 hall medication storage room on August 6, 2013, at 2:00 p.m., with Licensed Practical Nurse (LPN #1) revealed in the top right cabinet a bottle of rubbing alcohol, two tubes of Capsaicin ointment, an opened diet cola, three cans of disinfectant spray and two cans of air freshener. Further observation of the 100 medication storage room revealed no temperature gauge for the medication refrigerator. Interview On August 6, 2013, at 2:00 p.m., with LPN #1 confirmed the medications, chemicals, and the diet cola were not stored properly. Additional interview with LPN #1 confirmed the absence of the thermometer.	F 431	LPN #1 removed rubbing alcohol, the two tubes of Capsaicin ointment, the open diet coke, the three cans of disinfectant spray, and the two cans of air freshener and obtained a temperature gauge for the medication refrigerator on 8/6/13. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that have medications stored in the medication storage rooms have the potential to be affected. All facility medication rooms were audited by Unit Mangers on 8/7/13 to ensure that chemicals and/or soft drinks are not stored with medications and that the medication refrigerators have a temperature gauge in place. Licensed nursing staff will be educated by the Director of Nursing and/or Staff Development Coordinator by 8/26/13 to ensure that chemicals and/or soft drinks are not stored with medications and that the medication refrigerators have a temperature gauge in place. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;** Licensed nursing staff will be educated by the Staff Development Coordinator upon hire and annually to ensure that chemicals and/or soft drinks are not stored with medications and that the medication refrigerators have a temperature gauge in place. Evening Nurse Supervisor will audit	
F 465	483.70(h)	F 465		

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F 465 SS=D	Continued From page 19 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a sanitary, odor free environment for one (#40) of thirty-five residents reviewed. The findings included: Observation on August 5, 2013, at 10:00 a.m., in resident #40's room revealed a strong urine odor and a sticky floor. Observation on August 6, 2013, at 8:00 a.m. and 10:30 a.m., of the resident's room revealed the resident was out of the room and the bed was made, and a strong urine odor was present. Interview on August 6, 2013, at 8:43 a.m., with Licensed Practical Nurse (LPN) # 3 and Housekeeper #1 in the resident's room confirmed the room had a strong urine odor and the floor was sticky. Continued interview with LPN #3 revealed the resident's roommate urinates on the floor in the room daily and observed a yellowish brown area on the floor between the resident's beds. Observation and interview on August 7, 2013, at 8:50 a.m., with Minimum Data Set Coordinator #1 and Certified Nurse Assistant #5 in the resident's	F 465	100% of facility medication storage rooms weekly X4 and monthly X2 to ensure that chemicals and/or soft drinks are not stored with medications and that the medication refrigerators have a temperature gauge in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Director of Nursing to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. F465 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #40 room was cleaned and sanitized by environmental services on 8/6/13. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that reside in the facility have the potential to be affected. 100% of resident	09/26/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445298	A. BUILDING _____ B. WING _____	08/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ATHENS	1234 FRYE STREET, PO BOX 786 ATHENS, TN 37371

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F 465	Continued From page 20 room confirmed the resident's room had a strong urine odor and the floor was sticky.	F 465	rooms were audited by the Director of Environmental Services on 8/6/13 to ensure that resident rooms are sanitary and odor free. Nursing and environmental services staff will be educated by the Staff Development Coordinator and/or Director of Environmental Services by 8/26/13 to ensure that resident rooms are sanitary and odor free. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;** Nursing and environmental services staff will be educated by the Staff Development Coordinator and/or Director of Environmental Services upon hire and annually to ensure that resident rooms are sanitary and odor free. The Assistant Director of Environmental Services and/or Director of Environmental Services will audit 10% of resident rooms weekly X4 and monthly X2 to ensure that resident rooms are sanitary and odor free. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Director of Environmental Services to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated.	